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Occupational Justice—Bridging theory and practice

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Abstract
The evolving theory of occupational justice links the concept to social justice and to concerns for a justice of difference: a justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences. The purpose of this descriptive paper is to inspire and empower health professionals to build a theoretical bridge to practice with an occupational justice lens. Using illustrations from a study of leisure and the use of everyday technology in the lives of very old people in Northern Sweden, the authors argue that an occupational justice lens may inspire and empower health professionals to engage in critical dialogue on occupational justice; use global thinking about occupation, health, justice, and the environment; and combine population and individualized approaches. The authors propose that taking these initiatives to bridge theory and practice will energize health professionals to enable inclusive participation in everyday occupations in diverse contexts.

Key words: Ageing, diversity, everyday technology, leisure, person-centred practice, population health, social determinants of health, social inclusion

Introduction
The concept of occupational justice emerged through a dialogue that began with Wilcock's vision of an occupationally-just world supported by public health and societal initiatives, and Townsend's vision of engaging in professional practice with an ethical, moral, and civic commitment to enable the empowerment and social inclusion of persons, individually and collectively, in the everyday occupations of societies (1,2). Bridging the gap between the concept and practice of occupational justice will require health professionals to change practice (3,4), in particular to mobilize around a health advocacy agenda based on global thinking (5).

The purpose of this descriptive paper is to inspire and empower health professionals to build a theoretical bridge to practice with an occupational justice lens. An occupational justice lens may be used to advance toward the vision of an occupationally-just world by enabling the empowerment and social inclusion of populations who routinely experience social exclusion, such as disabled people, especially disabled women who experience domestic violence (6,7). We argue that an occupational justice lens may inspire and empower health professionals to engage in critical dialogue on occupational justice; use global thinking about occupation, health, justice, and the environment; and combine population and individualized approaches. The argument is made with illustrations from a study of leisure and the use of everyday technology in the lives of very old people in Northern Sweden, and with attention to the challenges for health professions of bridging theory and practice (8). Because occupational therapy was founded on a social vision of justice (6,7,9), we use this as an example of a health profession that intends to bridge theory and practice with a justice lens.

Overview of occupational justice theory
Although the concept and definitions are evolving, and like any concept will vary in different socio-
cultural contexts (13), occupational justice has been described from a Western perspective as a justice of difference: a justice to recognize occupational rights regardless of age, ability, gender, social class, or other differences (1,2,14). The central point is that occupational injustice is an outcome of social policies and other forms of governance that structure how power is exerted to restrict participation in the everyday occupations of populations and individuals (9). The governance of societies is typically structured so that some people experience social inclusion, privilege, and entitlement to choose what they do, while others experience social exclusion and restrictions, such as deprivation of full participation in everyday occupations (15). Implementing occupational justice will be challenging for health professionals for many reasons: multidisciplinary and multi-agency teams include members with different values, beliefs, and practice methods (4); and, some team members may view justice as outside their scope of practice.

The concept of occupational rights (1,6,7,14) is complementary to the concept that humans are occupational beings who need and want to engage in doing, being, becoming, and belonging (16). The reasoning is that the human species needs and wants to engage in occupations for survival, to connect with others, and to build communities. If occupation, like air, food, and water, is necessary for humans (16) it follows that humans and societies would advance toward an occupationally-just world by defining human rights to include participation in occupations (1,6,7,14).

Key social structures that govern participation in occupations in all societies are the division of labour and the classification of occupations (17,18). The division of labour refers to the cultural organization of particular activities or occupations to socially include or exclude particular groups, such as the typical allocation of housework and parenting to women and manual labour to men (17). Whether intended or not, participation restrictions produced by stereotypical divisions of labour lock some populations out of occupational opportunities. An example is that health professionals may lack the mandate and funding to exert labour in organizing leisure occupations that would be meaningful to older people, whereas the mandate and funding may be available for them to target leisure for children, adolescents, and adults. Similarly, when occupations are classified as suitable for men or women, or duties and responsibilities are attributed as unsuitable for those of a particular age, the classifications result in economic and social privileges for some and restrictions for others. For instance, occupations, such as leisure, that are organized without arrangements to include older persons marginalize this population. Occupational rights or restrictions are implied in the division of labour and occupational classifications because rights are embedded in the sociocultural beliefs and values, health and other practices, policies, laws, and economic or economic conditions that prompt a society to define who will do what, where, when, how, and with which resources. The division of labour, occupational classifications, and other structural forms of governance are part of what is called the environment in occupational therapy models, such as the Canadian Model of Occupational Performance and Engagement (10), environmental forces in the International Classification of Function, Disability and Health [ICF] (19) and the social determinants of health in health and social policy (20).

An occupational justice framework published by Stadnyk et al. (14) displays how structural and contextual factors contribute to occupational justice or injustice. Beyond defining health practice outcomes in terms of what people do (occupational performance) or how, where, when, and why they engage in their occupations (occupational engagement), occupational outcomes are connected to occupational rights that encompass inclusive participation in everyday occupations.

The Stadnyk et al. (14) framework displays occupational injustice when some populations more than others are restricted from experiencing occupational rights, responsibilities, and liberties, either deliberately or through taken-for-granted social exclusion from participation, at any point across the lifespan, in the occupations typical of their community. From a Western cultural perspective, Stadnyk et al. (14) propose four overlapping compounding forms of social exclusion and related occupational rights that are part of the current dialogue on occupational justice.

1. Occupational alienation: social exclusion by restricting a population from experiencing meaningful and enriching occupations (6,7).
2. Occupational deprivation: social exclusion by restricting a population in diverse contexts, such as prisons, refugee camps, care facilities, or other isolating situations, from participating in occupations that would promote their health and well-being (15).
3. Occupational marginalization: social exclusion by restricting a population from experiencing autonomy through lack of choice in occupations (7,14).
4. Occupational imbalance: social exclusion by restricting a population so that some people have too little to do every day while others
have too much to do, instead of all persons experiencing participation in a range of the occupations that would promote their health and well-being (21).

**Study methods and results: occupations of older people**

Health professionals regularly observe occupational injustice although they may not be aware of doing so. Practitioners who have worked in or visited nursing homes will recognize the scene of an older, male resident sitting and sleeping in his wheelchair in front of a music-show on the television. One could imagine that he did not choose this occupation himself, and that he fell asleep because he was put in front of a programme in which he had no interest. He was not able to change the programme on his own and he was not able to move to another place. Perhaps there were other reasons. Nevertheless, many people in nursing homes lack the ability and opportunities for choosing and engaging in a balanced array of meaningful occupations each day as a means of promoting health and well-being (22).

Awareness that some very old people are not very engaged in daily occupations prompted a collaborative, population-based occupational therapy study of people who were aged 85 years or older (very old) in northern Sweden (23,24). People who scored 19 or lower on the Mini-Mental-State-Examination (MMSE) were not included. The study (23,25), continuing since 2001, includes more than 250 persons living in ordinary housing as well as nursing homes; persons with many or a few medical diagnoses; and persons living in extreme rural areas as well as in a mid-sized city. Home visits were used to administer a battery of self-rating questionnaires on leisure amongst other things.

**Occupational arenas of leisure and using everyday technology**

Before data collection, questions were raised by some research colleagues and community members who assumed that research on leisure for very old people would be meaningless. These assumptions may reflect widespread yet subtle ageism attitudes in health professions and society (26). The questions also illustrate how social attitudes may contribute to occupational injustice by excluding very old people from research that would examine and potentially support their participation in leisure occupations. None of the very old people in the study questioned what was meant by leisure; instead they said that leisure was something no one had asked them about before. It seems that very old people have a diverse repertoire (27) of leisure occupations that require social, cultural, and physical participation (as with younger people). Yet, typical rehabilitation programmes for very old people do not address leisure, but focus instead on mobility, dressing, grooming, and other basic self-care occupations, as if this is all there is to their lives (28).

Almost all of the very old persons in the study reported that they watch a great amount of television (27). One might view this leisure occupation as passive and contrary to a vision of active, healthy ageing. The interviews, however, suggest that television is no passive occupation for very old people but rather is a way to stay updated on what is going on around the world. They want to keep updated not only because they are curious, but also because they want to talk about television shows, news, and weather forecasts with their families, neighbours, and friends.

An unexpected finding coincided with the change in Sweden from analogue to digital television transmission, as this required many people to acquire a new technology. Those who wanted to watch without buying a new television needed to install a box with a remote control. Many of the very old people did not have any experience or skills in using a remote control. Instead of being able to see their television programmes freely as they wanted or needed to, many had to develop a fixed television-watching schedule or rely on family members to help them to switch the set on and off and change programmes. The very old people also spoke at great length about their technology challenges in using the Internet as a leisure occupation. They talked about feeling that without access to the Internet they were not true members of the state because so many things that they found interesting “slipped through their fingers”. One man was angry during his interview saying:

“You know when you are looking at the news and there is an interview that seems very interesting then they just cut the story and say that you can see the whole interview on the web—of course I cannot—I do not even have a computer.”

**Discussion**

Excerpts from the study of very old people open avenues to engage in critical dialogue on occupational justice; use global thinking about occupation, health, justice, and the environment; and combine population and individualized approaches. Two questions are posed to spark dialogue on the occupational rights of very old people, global thinking about the occupational arenas of leisure and everyday technology for very old people, and the
potential for health professionals to work with and for very old people by combining population and individualized approaches.

**Do very old people have an occupational right to engage in leisure activities of their choice?**

The Swedish study found no evidence that very old people only want a life of washing their face, eating, and putting on their sweater. Conversely, there is growing evidence that occupational engagement by very old people can promote their health (25). Yet within health services, rehabilitation programmes typically focus on what is described as Personal Activities of Daily Living (PADL) or Instrumental Activities of Daily Living (IADL) that largely evaluate individuals’ abilities in self-care and homemaking occupations (29). Moreover, while instruments that measure PADL or IADL are typically validated for use with individual, older people (30), only a few measure occupational engagement in leisure by very old people as individuals or as a population in any context (23).

Well-meaning healthcare professionals, including occupational therapists, may actually be restricting social inclusion when services overlook leisure for very old people as a population and instead focus on individual self-care occupations as defined by practice protocols. Whether or not these are meaningful categories to very old people, and whether they really want to engage in them, is not considered (31). Very old people may be an occupationally alienated population when support workers, health professionals, and family members repeatedly and in many contexts set individuals in front of a television without knowing whether this is meaningful to them. Health professionals may inadvertently undermine occupational justice for older, especially very old people, when there is limited awareness that occupations continue to be as necessary as air, food, and water even in very old age (1,2,6,7,16).

Health professionals could take responsibility to challenge this status quo and combat stigma by planning both population and individualized strategies for working with very old people. Since health professionals support the rights of people with mental illness (32), health professionals could also give voice to the ethical, moral, and civic entitlement to leisure of very old people. The alienation of very old people may be compounded by the silence of health professionals who overlook participation in leisure for very old people, in the same way that people are alienated by silence around sexuality and disability (33). To date, the leisure occupations of very old people, such as television watching or meeting with friends, are absent from the typical division of labour and occupational classifications that are oriented to the occupations of employed adults (17,18). The idea of classifying leisure occupations for very old people may seem outlandish, yet research shows that lack of leisure may undermine the health and well-being of very old people (14,15,25) and that health services that focus mainly on self-care may not be relevant to what very old people really need and want to do (31). One question to discuss is whether the social and economic costs of health professionals not addressing leisure as an occupational right are higher than enabling very old people individually and as a population to stay healthy and active in their communities.

**Does lack of access to everyday technology infringe on the occupational rights of very old people?**

Everyday technologies such as television, remote controls, and the Internet have made life easier in many ways, but until they learn how to handle them very old people may be excluded as a population from participation in their desired occupations. People of all ages rely increasingly on digital communication where information, knowledge, and services are available, and sometimes only available through the television, Internet, and cell phones. Television and other remote control systems and computer use are widespread: in fact, Sweden is amongst the countries with the highest level of access to the Internet in the world (34). Very old people may not use the Internet like younger groups because they do not understand how to use and gain from it: as a result they tend to be ignored as computer and Internet users. Despite the amount of information and services available on television and the Internet, in Western countries especially, older people seem to be an excluded group (35).

The Internet may enable some people to engage in their occupations, but the Internet can also restrict or even prevent very old people from fully participating in society (36). Very old people may be occupationally marginalized without the right to autonomy in their occupational experiences when inexperience with television remote controls and the Internet exclude them from family and community participation. Marginalization may be compounded because they may also be occupationally deprived when they are isolated from real or virtual community inclusion by the lack of access to or inability to use television remote controls, the Internet, and other everyday technologies. Occupational imbalance may exist as, without access to everyday technologies, very old people cannot exercise the occupational privilege of participating in a range of occupations. For those very
old people who live alone with nothing to do except self-care, or who have heavy responsibilities for caregiving or home management, using the television and Internet enables them to keep up to date and gain social support from watching television as a diversion or for information on care-giving. Western societies typically focus on adult occupations, and not those of very old people. Very old people seem to be rendered obsolete by technologies because they are not designed for their use. One question to discuss is whether health professionals might develop policies and practice protocols for local and national partnerships with the telecommunications industry to enable older citizens to participate in leisure and community occupations as a health-promotion strategy.

**Implications for health professionals:**

**Building a theoretical bridge to practise with an occupational justice lens**

While narrow, skill-based job descriptions, restrictive policies, funding limitations, and diverse multidisciplinary team expectations present challenges for health professionals (3,4,9), the implications for health professionals to practise with an occupational justice lens are optimistic. Opportunities exist to build a theoretical bridge to practice with very old people and other populations using this lens. Health professionals could bridge the gap (3) between a theoretical lens and practice by such actions as: negotiating how multidisciplinary teams might combine individualized practice with population and community development initiatives; building coalitions for advocacy in professional, consumer, community, and industry partnerships; and organizing non-partisan, strategic, political action (37), with awareness of the political nature of health professional practices (38).

**Implications illustrated in occupational therapy**

An example of the potential for greater health professional leadership to combine population and individualized approaches is offered by an outcome of the study reported here. Leisure occupations have been included in the occupational therapy rehabilitation programme for older, especially very old people in the community in Northern Sweden. A checklist for leisure occupational engagement has been developed and validated as an individualized outcome measure for older people (39). The problem with remote controls is widespread and has been referred to the Swedish Institute for Assistive Technology.

Given occupational therapists’ increasing attention to populations as well as individuals (10,40,41), population approaches were the starting point for a project to enable older people to participate in Internet-based occupations. The project explored the needs of very old people to use the Internet and their interest in participating in an Internet café as a meeting-place to bridge the digital gap (36), as well as to match their needs to available resources in the community. Results showed that very old users as well as non-users would come to an Internet café to meet others and develop or enhance their Internet skills. In recognizing the use of the Internet as an occupation with therapeutic and health-promoting potential, occupational therapists advocated for and started this programme to enable very old people to become Internet users. A collaborative project is ongoing between occupational therapists and computer scientists to develop a web-based portal with individual profiles to meet both the population and individual needs and motivation of very old people (42).

With a commitment to person-centred enablement for individual and social change (historically called “client-centred” practice) (10), strong occupational therapy leadership could inspire and empower this and other professions to coordinate different approaches for advancing visions of health, well-being, and justice. Occupational therapy leadership could also inspire and empower this and other health professions to advance their competence and critical dialogue on a spectrum of collaborative enablement skills and the continuum of effective, minimal, missed, and ineffective enablement, contrasted with hierarchical, professional dominance and negative, co-dependent enablement [10, pp. 111–131]. For instance, occupational therapy leadership could enable interested members of health professional teams to develop enablement skills and the critical reflection needed to educate the community about occupational injustice, adapt or re-design programmes to include real-life occupations as a strategy to engage people in helping themselves, and advocate with consumer groups and families for change where participation restrictions exist. By encouraging a multidisciplinary health professional team to build alternative service models to enable everyday living beyond treating medical symptoms, occupational therapists could contribute leadership to the development, coordination, and management of combined population and individualized approaches to health promotion, primary healthcare and rehabilitation with many populations, including very old people, across any sector from employment, housing, industry, transport, and education to social services and health.

Wood et al. (12) state that the concept of occupational justice gives voice to occupational therapists’
implicit historical and ethical stance to address potential or real injustices. White (11) describes occupational justice as fundamental to occupational therapy: “Once a practitioner has embraced the basic philosophy of the profession (i.e., that occupational engagement and meaningful occupation are essential for health and well-being and the environment either supports or constrains occupational performance), it is difficult to think about how occupational therapy would not be used to promote occupational justice” (11). Hammell (6) states “Occupational therapy could be the profession committed to attaining occupational rights and to enabling people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities” [p.62]. She further states (6), “An engagement with occupational rights will bring our practice [occupational therapy] into line with our espoused belief in the relationship between occupation and human well-being, acknowledge the connection between human well-being and human rights, and enable us to state, unequivocally, what occupational therapy contributes to humanity” [p. 63]. Based on this study and follow-up projects with older and very old people in Sweden, it seems that occupational therapists have great potential to take up the challenges and opportunities of building a stronger theoretical bridge to practice with an occupational justice lens. In doing this, occupational therapists could lead multidisciplinary teams to enable more inclusive participation in everyday occupations by different population groups and individuals in a variety of contexts.

Conclusion

In this paper, we have argued that an occupational justice lens may inspire and empower health professionals to build a theoretical bridge to practice with an occupational justice lens. An occupational justice lens may be used to advance towards the vision of an occupationally-just world with an ethical, moral, and civic commitment to enable the empowerment and social inclusion of populations who routinely experience exclusion. By engaging in critical dialogue on occupational justice, using global thinking about occupation, health, and justice, and combining population and individualized approaches, health professionals may be energized to focus practice on the social policies and other forms of governance, also described as environmental forces (10,19) or social determinants of health (20), that structure what people do every day and their inclusion in society. Illustrations from the literature and research on very old people’s leisure and use of everyday technology in Northern Sweden illustrated how very old people face occupational injustice when they cannot exercise occupational rights. They face occupational alienation and imbalance without access to a range of desired leisure occupations beyond self-care, and occupational deprivation and marginalization because they are deprived and marginalized from participation in leisure, especially by the complexity of everyday technologies, such as television remote controls and the Internet.

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